MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

07174

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Brown's Woods R.F.D. #2 Annapolis. Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County A.A.
City or town Brown Wood Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Rural
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Foetus. 6½ months miscarriage Adams

3. (b) Social Security Number

4. Sex: Male
5. Color or race: negro
6. (a) Single, married, widowed, or divorced: —
6 (b) Name of husband or wife —
6(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) July 23. 1940
8. AGE: Years | Months | Days | If less than one day hrs. 0 min.
9. Birthplace Brown's Wood R.F.D. #2 Annapolis Md
(Town, county, and state)
10. Usual occupation —
11. Industry or business
FATHER
12. Name Robert Pack
13. Birthplace Md
MOTHER
14. Maiden name Thelma Adams
15. Birthplace Mulberry Hill, A.A. Co. Md
16. Informant Harriett Adams
Address Brown's Woods R.F.D. #2 Annapolis
17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory Browns Woods
Location A.A.
18. Funeral director Hezekiah Adams
Address Browns Wood A.A.
19. 7-23 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 23 1940, at 4A M
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem examination
~~and that I last saw he~~ ~~or alive on~~ 19
Immediate cause of death Miscarriage — DURATION 6½ mos.
Due to Syphilis
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE John McCleffy Deputy medical examiner M. D. or other
Address Annapolis Md Date signed 7/23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

07175

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 yrs 3 mos 14 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 3 yrs 3 mos. 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Cumberland St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Luther (Henry Luther) Anderson

3.(b) Social Security Number: —

4. Sex: Male

5. Color or race: Black

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1885 (?)

8. AGE: Years: 55 Months: ? Days: ? If less than one day: ..... hrs. ..... min.

9. Birthplace: West Virginia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Wills Anderson
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Margaret Baker
15. Birthplace: West Virginia

16. Informant: Hospital Records

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 31 1940 (month) (day) (year)

Cemetery or crematory: Orrick Cemetery

Location: Winchester, Va

18. Funeral director: J.G. Cartwright

Address: 510 N. Kent St. Winchester, Va

19. 7/28-40 19 (Date rec'd by registrar) E.F. Joyce D.L. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1940, at 10 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13, 1937, to July 27 1940 and that I last saw him alive on July 27th 1940

Immediate cause of death: Arteriosclerosis — DURATION: Unknown

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Herbert P. Winkoods M. D. or other

Address: Date signed

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121-a)

CERTIFICATE OF DEATH

07176

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Ft. Meade Road
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 20 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(If newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Fort Meade Road
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Henrietta Scala Arth

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: Joseph A. Arth
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 21, 1849.

8. AGE: Years	Months	Days	If less than one day
90	11	5	hrs. min.

9. Birthplace: Washington, D. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: own home

FATHER	12. Name	Francis Mario Scala
	13. Birthplace	Naples Italy
MOTHER	14. Maiden name	Mary Ellen Woods
	15. Birthplace	Washington, D.C.

16. Informant: Mrs Grace Arth
Address: Gambrills. Md

17. (Burial, cremation, or removal. Which?) Date thereof: 7-29-40 (month) (day) (year)
Cemetery or crematory:
Location: Washington D.C.
18. Funeral director: J. William Lee's Sons
Address: 300-4th St. N.E. Wash. D.C.
19. 7/26 40 (Date rec'd by registrar) E. F. Joyce (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 26 1940, at 9 35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1940, to July 26 1940, and that I last saw her alive on July 26 1940.

	DURATION
Immediate cause of death: Cardio-renal disease	3 mos.
Due to: Arterio-sclerosis	2yrs.
Due to: — — —	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations: — — — —
Of autopsy: — — — —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Claffy, M. D. or other
Address: Annapolis, Md Date signed: 7/26/40

RECEIVED
AUG 5 1940
BUREAU V. S.

Exhibit C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

07177

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Orchard Beach
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Virginia County
City or town Norfolk Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Howard Belvin

3. (b) Social Security Number

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife ----------
---------- 6(c) If alive, give age --- years

7. Birth date of deceased (mo., day, yr.) August 15, 1923.

8. AGE:

Years	Months	Days	If less than one day
16	11	13	— hrs. — min.

9. Birthplace Portsmouth Norfolk Virginia
(Town, county, and state)

10. Usual occupation Student

11. Industry or business ----------

FATHER
12. Name Unknown
13. Birthplace Unknown

MOTHER
14. Maiden name Unknown
15. Birthplace Unknown

16. Informant Individual Record, CMTC Camp, Ft. Meade,
Address Md., J. J. Madigan, Lt. Col., M.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof July 29, 1940 (month) (day) (year)
Cemetery or crematory To Norfolk, Va.
Location

18. Funeral director T. A. Hardesty & Son.
Address

19. ---------- 19---- ----------
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1940, at 1:40 p.m.

21. I CERTIFY that death occurred on the date above stated; ~~that attended deceased from~~
Post mortem examination
~~and that last saw he was alive on~~ July 28 1940

Immediate cause of death
Drowning
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 7/28/40
Where did injury occur? Orchard Beach A.A. Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Stoney Creek
Means of injury fell from row boat Injured at work? No

23. SIGNATURE John M. Claffy Deputy medical examiner
M. D. or other
Address Annapolis, Md. Date signed 7/28/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(T)

to H. G. Oliver
Norfolk Va.

call T. A. Handesty
Glendale. Md
West River 201 X 2

RECEIVED
AUG 16 1940
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

07178

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: A. A.
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 10 Block st.
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 10 Block
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME Magil Bond

3. (b) Social Security Number

4. Sex: Fem
5. Color or race: Colored
6. (a) Single, married, widowed, or divorced: widow
6 (b) Name of husband or wife: Robert Bond
6(c) If alive, give age: 68? years
7. Birth date of deceased (mo., day, yr.): March 18 1878
8. AGE: Years: 62 Months: 4 Days: 2 If less than one day: hrs. min.
9. Birthplace: West Rock (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name:
13. Birthplace: Unknown
MOTHER 14. Maiden name:
15. Birthplace: Unknown
16. Informant: Birdie Mathews
Address: 10 Block st
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 25 1940 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis, Md
18. Funeral director: J. B. Johnson
Address: Annapolis
19. 7 22 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 20 1940, at 7 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7 1940 to July 20 1940, and that I last saw her alive on July 20 1940

	DURATION
Immediate cause of death: Cardio-Renal Disease	about 3 mo.
Due to:	
Due to:	
Other conditions: Pleurisy	6 mo.

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Laurence W. Greene, M.D.
M. D. or other
Address: Annapolis Md. Date signed 7/22/40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

Dr. Richardson

CERTIFICATE OF DEATH

07179

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A.

City or town Parole Md (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County A. A.

City or town Parole Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. — (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Louisa Boston

3. (b) Social Security Number 220-03-1462

4. Sex: Fem.

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: widow

6 (b) Name of husband or wife: James Boston

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Dec. 24 1869

8. AGE: Years 70 | Months 7 | Days 1 | If less than one day ____ hrs. ____ min.

9. Birthplace: Bristol A. A. Co. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: Forester Sergent.

13. Birthplace: Bristol. Ind.

MOTHER — 14. Maiden name: Henretta Sergent

15. Birthplace: Bristol. Md

16. Informant: George Boston

Address: Parole. Ind.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 28/40 (month) (day) (year)

Cemetery or crematory: Brewer Hill

Location: Annapolis

18. Funeral director: J. B. Johnson

Address: Annapolis

19. 7/28/40 (Date rec'd by registrar) J. H. Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 27 1940, at 12:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 10th 1940 to July 25th 1940 and that I last saw her alive on July 25th 1940

	DURATION
Immediate cause of death: Cerebral Apoplexy	47 days
Due to: Arteriosclerotic Hypertension	6 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE R. L. Richardson M. D. or other

Address Annapolis Md. Date signed 7/27/40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

07180

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Anne Arundel

City or town District No. School

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: District No. School

Stay in hospital or inst. (yrs., or mos., or days) 10 yrs.

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County A. A. County

City or town District No. School Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Maurice Brown

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	negro	single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 5, 1924

8. AGE: Years 16 | Months 4 | Days 25 | If less than one day hrs. min.

9. Birthplace District of Columbia

(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER 12. Name McKinley Brown

13. Birthplace unknown

MOTHER 14. Maiden name Hattie Brown

15. Birthplace Virginia

16. Informant Records of District No. Sch.

Address near Laurel Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/31/40 (month) (day) (year)

Cemetery or crematory Cemetary

Location District No. School

18. Funeral director District No. School

Address

19. July 31 1940 (Date rec'd by registrar) Clara M. Hasleup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 30 1940, at 12:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 1934, to July 30 1940, and that I last saw him alive on July 30 1940.

	DURATION
Immediate cause of death: Status Epilepticus	10 hrs
Due to: Heriditary atrophy of Brain Congenital	Life
Due to:	
Other conditions: Epilepsy	Life
Idiocy	Life

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy Heriditary atrophy of Brain

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James Brooks M. D. or other

Address District No. Sch. Date signed 7/31/40

RECEIVED
AUG 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(94a)

07181

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Anne Arundel

City or town Glen Burnie
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Crain Highway

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) Life

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Glen Burnie Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Crain Highway
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR None

3. (a) FULL NAME William F. Bussey Sr.

3. (b) Social Security Number 705-10-0830

4. Sex: Male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife Margaret T. Bussey Nee Tepper

6(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) December 1, 1885

8. AGE: Years 54 | Months 7 | Days 26 | If less than one day ___ hrs. ___ min.

9. Birthplace Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation Railroad Engineer

11. Industry or business Baltimore & Ohio R.R.

FATHER
12. Name John F Bussey
13. Birthplace Berlin Germany

MOTHER
14. Maiden name Emma Poess
15. Birthplace Germany

16. Informant Mrs. Frederick Aschemeyer
Address Glen Burnie, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof July 29, 1940 (month) (day) (year)

Cemetery or crematory Cedar Hill

Location Anne Arundel Co.

18. Funeral director Thomas W. Singleton
Address Glen Burnie, Md.

19. July 28 1940 (Date rec'd by registrar) Mrs. DeAlba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1940, at 2:04 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JAN. 1940 19 ___, to JULY 1940, and that I last saw him alive on JULY 25 1940.

Immediate cause of death: CORONARY HEART DISEASE

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

DURATION: UNKNOWN

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John J. Alexander
M. D. or other
Address Glen Burnie Date signed 7/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

(M) (I) (T)

RECEIVED
JUL 31 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

07182

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 7 Acton Place
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): April 1 1940

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: District of Columbia County:
City or town: Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Edgar Bassett Calvert

3. (b) Social Security Number:

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Anna S Calvert
6(c) If alive, give age: 63 years
7. Birth date of deceased (mo., day, yr.): Oct 29 - 1870

8. AGE: Years: 69 Months: 8 Days: 10 If less than one day: hrs. min.

9. Birthplace: Petersburg Va (Town, county, and state)
10. Usual occupation: Meteorologist
11. Industry or business: Weather bureau

FATHER
12. Name: James Edgar
13. Birthplace: Va

MOTHER
14. Maiden name: Sally Ann Walton ~~Anna Stehley~~
15. Birthplace: Chicago Illinois

16. Informant: Mrs Virginia Compton
Address: 7 Acton Pl. Annapolis, Md

17. Cremation (Burial, cremation, or removal. Which?) Date thereof: July 9 1940 (month) (day) (year)
Cemetery or crematory: Fort Lincoln
Location: Bladensburg Md.

18. Funeral director: T. A. Hardesty & Son
Address: Golesville

19. 7/9 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 9 1940 at 2 10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1940, to July 9 1940, and that I last saw him alive on July 9 1940.

Immediate cause of death: Cr. Myocarditis — DURATION: Several mos.
Due to: Secondary Anemia — "
Due to:
Other conditions: Large Cancer of Stomach. — about 1 yr.
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: J. Olivier Purvis M. D. or other
Address: Annapolis Md Date signed: 7/9/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 1 1940
BUREAU V. S.

50
75
25
150

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

07183

CERTIFICATE OF DEATH

Reg. Dist. No. 2-1

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 5 mos. 12 das.

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 yrs. 5 mos. 12 das.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Howard

City or town: Elkridge
(If outside city or town limits, write RURAL and give nearest town)

Street No.: -----
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: WILLIAM CHAMBERS

3.(b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	single

6.(b) Name of husband or wife: ------

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec. 4, 1916

8. AGE: Years	Months	Days	If less than one day
23	6	28	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: CCC Camp

11. Industry or business: -----

FATHER
12. Name: William Chambers
13. Birthplace: Maryland

MOTHER
14. Maiden name: Hattie Rawlings
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-4-40 (month) (day) (year)

Cemetery or crematory: St. Stephens

Location: Elkridge, Md.

18. Funeral director: T. C. Higinbotham

Address: Ellicott City, Md.

19. July 1 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 1st, 1940, at 4:15P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19th 1938, to July 1st 1940 and that I last saw h..... alive on July 1st 1940

Immediate cause of death	DURATION
Tuberculosis of the intestines and peritoneum	4 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. 4/1/40

Autopsy results: ------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ---- Date of .....

Where did injury occur? ---- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury: ..... Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 7/1/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

07184

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Emergency Hospital.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: X

3.(a) FULL NAME: Baby Clayton (Girl) (Twin)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25th 1940

8. AGE: Years — Months — Days — If less than one day ..... hrs. ..... min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Raymond H. Clayton
13. Birthplace: Madisonville Ky.

MOTHER
14. Maiden name: Malessia Fay Wynette
15. Birthplace: Austenville Va

16. Informant: Raymond H. Clayton
Address: Millersville R.R.C. Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof July 27 1940 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. July 26th 1940 (Date rec'd by registrar) J. M. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25 1940 at 8.30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1940 to July 25 1940

and that I last saw h alive on 19

Immediate cause of death	DURATION
Stillborn	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other

Address: Annapolis Md Date signed 7/26/40

RECEIVED
AUG 5 1940
BUREAU V. S.

07185

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(8)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Emergency Hotel

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war (Twin)

3. (a) FULL NAME Baby Girl Clayton (Girl)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25th 1940

8. AGE: Years | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Raymond H. Clayton
13. Birthplace: Madisonville Kt.

MOTHER
14. Maiden name: Malessia Fay Winesette
15. Birthplace: Austinville Va

16. Informant: Raymond H. Clayton
Address: Millersville A. A. Co Md

17. (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md.

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. July 26th 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 25, 1940, at 8:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 25 1940, to July 25, 1940 and that I last saw ..... alive on ..... 19.....

Immediate cause of death: Stillborn

Due to: Baby

Due to:

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations ..... Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Albert L. Anderson MD
M. D. or other

Address: Annapolis, Md. Date signed: 7/26/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(8)

07186

Reg. Dist. No. 71

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County A.A.

City or town West Annapolis Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Monroe (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Still Born Cloud

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

B(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 31 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Annapolis (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Eugene W. Cloud

13. Birthplace South Carolinia

MOTHER 14. Maiden name Victoria A. McKay

15. Birthplace Baltimore, Md.

16. Informant Eugene W. Cloud

Address Monroe St. West Annapolis

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis, Md.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19 8 1 19 40 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH about July 1 1940, at — M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death Still Born

Due to 6 1/2 month developed

Due to child died intrauterine about July 1/40

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver Purcell M. D. or other

Address Annapolis Md. Date signed Aug 1/40

RECEIVED
SEP 5 1940
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

07187

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH (131-2)

County Anne Arundel Registration Dist. No. 21

Village or City Rutland No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U. S. If of foreign birth? yrs. mos. ds.

2. FULL NAME Emma Isabella Donaldson If U. S. Veteran, specify WAR

(a) Residence: No. a. a. Co. Maryland St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)
F.	W	Married

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of U. S. Donaldson

6. DATE OF BIRTH (month, day, and year) Mar. 23-1864

7. AGE	Yeers	Months	Deys	If LESS than 1 dey, hrs. or min.
	76	3	17	

OCCUPATION

8. Trade, profession, or particular kind of work done, es SPINNER, SAWYER, BOOKKEEPER, etc. Housewife

9. Industry or business in which work was done, es SILK MILL, SAW MILL, BANK, etc. X

10. Date deceesed lest worked et this occupation (month and yeer)

11. Totel time (years) spent in this occupetion

12. BIRTHPLACE (city or town) (State or country) Balto. Md.

FATHER

13. NAME Frederick Sinskey

14. BIRTHPLACE (city or town) (Stete or country) England

MOTHER

15. MAIDEN NAME Mary Tatlore

16. BIRTHPLACE (city or town) (State or country) Germany

17. INFORMANT (Address) Edgar F. Donaldson R. F. D. Annapolis Md.

18. BURIAL, CREMATION, OR REMOVAL Place Woodwardview Md. Dete July 12, 1940

19. UNDERTAKER (Address) B. B. Williams Waterbury Md.

20. FILED July 12, 1940 E. F. Boyce Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 10 (Day), 1940 (Yeer)

22. I HEREBY CERTIFY, Thet I attended deceesed from Jan. 12, 1940, to June 26, 1940

I lest sew h- alive on June 26, 1940; death is said to have occurred on the date stated ebove, at 2 A. m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were es follows:

	Date of onset
Arteriosclerotic heart disease	?
Other Contributory Causes of importance:	
Cerebral arteriosclerosis	?
Chronic glomerulonephritis	?

Neme of operation none Date of

What test confirmed diagnosis? none Wes there an autopsy? no

23. If deeth was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, In HOME, or in PUBLIC PLACE.

Menner of Injury

Neture of Injury

24. Was diseese or Injury in any way releted to occupation of deceased? no

If so, specify

(Signed) W. T. Fidler M. D.

(Address) Jamestown Md.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I		Example II	
The principal cause of death and related causes of importance were as follows:	Date of onset	The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*	*Attack of epilepsy*	*1 week ago*
Chronic interstitial nephritis	*1921*	*Run over by street car*	*1 week ago*
Cerebral hemorrhage	*July 5, 1927*	*Peritonitis*	*3 days ago*
Other contributory causes of importance:		Other contributory causes of importance:	
Gallstones	*May 1, 1923*	*Gastroenteritis*	*1 year*

RECEIVED
AUG 5 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-E)

CERTIFICATE OF DEATH

07188

22

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Jessup, Maryland (If outside city or town limits, write RURAL NEAR and give town)

Street address, Hospital, or Institution: XXXXX Maryland House of Correction

Stay in XXX or Inst. (yrs., or mos., or days): 5 Months-5Days

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Camp Parole Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Edward Evans

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife

(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): August 16th, 1898

8. AGE: Years	Months	Days	If less than one day
41	10	20	15 hrs. 30 min.

9. Birthplace: Camp Parole, Maryland. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Jim Boone

13. Birthplace: Deceased

MOTHER — 14. Maiden name: Harriett Wright

15. Birthplace: Deceased

16. Informant: Friends of Md H & C. Address: Jessup Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17-40 (month) (day) (year)

Cemetery or crematory: Cherry Hill

Location: Jessup Md

18. Funeral director: N L Collins Address: Jessup Md

19. July 17 1940 (Date rec'd by registrar) Elana M Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7th 1940, at 3.30 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6th, 1940, to July 7 1940, and that I last saw him alive on July 7th 1940

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease	?
Due to: XXX Chronic Nephritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Ot operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W. R. Trumpet, M.D. M. D. or other

Address: Maryland House of Correction, Jessup, Md. Date signed: 7-8-40

RECEIVED
AUG 7 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (138)

CERTIFICATE OF DEATH

07189

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: A A Co
City or town: Raynor Heights
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Nursery Rd & Fairview ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A A Co
City or town: Raynor Heights Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Nursery Rd & Fairview ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Henry F. Frank
3. (b) Social Security Number: SS 212-10-9969

4. Sex: M
5. Color or race: W
6. (a) Single, married, widowed, or divorced: Married
8 (b) Name ~~of husband~~ or wife: Alverta L
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): April 28 — 1881
8. AGE: Years 59 Months 2 Days 8 If less than one day ____ hrs. ____ min.
9. Birthplace: Germany (Town, county, and state)
10. Usual occupation: Iron Moulder
11. Industry or business
FATHER
12. Name: Ferdinand Frank
13. Birthplace: Germany
MOTHER
14. Maiden name: Caroline —
15. Birthplace: Germany
16. Informant: Alverta L Frank
Address: Nursery Rd & Fairview ave
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 29/40 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Annapolis ave
18. Funeral director: Edward Foulson
Address: 2359 Wash Blvd Balto Md
19. July 27 1940 (Date rec'd by registrar) M S De Alba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7/26 1940, at 2:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/10/39 19__ to 7/26/40 and that I last saw him alive on 7/26/40 19__
Immediate cause of death: Bilateral Pulmonary Tuberculosis
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

DURATION: Yrs

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: Joseph G. Lankartz MD
M. D. or other
Address: 679 Washington Blvd Date signed: 7/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 29 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07190

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 days

Hospital, Institution, or street address where death occurred: CROWNSVILLE STATE HOSPITAL

How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A. A.

City or town: Edgewater
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: -------

3. (a) FULL NAME: ROSE GALLOWAY

3. (b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6.(b) Name of husband or wife: McClain Galloway

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1913

8. AGE: Years: 27 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Unknown
(Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 14/40 (month) (day) (year)

Cemetery or crematory: Mt Hope

Location: Sunderland Md

18. Funeral director: B I Hopping

Address: 170 West St Annapolis Md

19. July 13 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11th 1940, at 1 A. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 2nd 1940, to July 11th 1940 and that I last saw her alive on July 11th 1940

Immediate cause of death	DURATION
Acute endocarditis	
Due to	
Due to	
Other conditions: -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ------

Accident, suicide, or homicide: ------- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 7/11/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13th)

CERTIFICATE OF DEATH

07191

Reg. Dist. No. 27

1. PLACE OF DEATH:
County A. A. Co.
City or town Near Hanover
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A. Co.
City or town Near Hanover Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Wm. Henry Gatewood

3. (b) Social Security Number 212-18-9309

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Col.	Married

6 (b) Name of husband or wife Nellie Gatewood
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan 11 - 1865

8. AGE: Years 75 | Months 6 | Days 29 | If less than one day hrs. min.

9. Birthplace Caroline Co Va
(Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Thos. Gatewood
13. Birthplace Caroline Co. Va.

MOTHER 14. Maiden name unknown
15. Birthplace

16. Informant Herbert Butler
Address Near Hanover R.D. Co

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 14 - 1940 (month) (day) (year)

Cemetery or crematory St. Matts.

Location Near Hanover R.D. A.A. Co.

18. Funeral director The H. C. White Co. Inc.

Address Laurel Md.

19. July 17 1940 (Date rec'd by registrar) Clara M. Haslup Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 10 1940 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 12 1940 to July 10 1940, and that I last saw him alive on July 18 1940.

	DURATION
Immediate cause of death: Myocardial + Cardiac Insuff.	4 hrs.
Due to: Mitral Stenosis	?
Due to:	?
Other conditions: Chr. Nephritis. Hypertension.	? ?

(Include pregnancy within 3 months of death)

Major findings:
Dt operations ✓
Dt autopsy ✓

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Frank Shipley M.D.
M. D. or other
Address Savage, Md. Date signed 7/13/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 7 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(183)

07192

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Greenland Beach

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: —

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 0

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Wagner's Point, Baltimore Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 3812 Leo Street

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: John Gorski

3. (b) Social Security Number: 215-03-3550 (Poss.)

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: single

6 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): April 16, 1913

8. AGE: Years: 27 Months: 3 Days: 4 If less than one day ____ hrs. ____ min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: sand blaster

11. Industry or business: Richfield Oil Co.

FATHER

12. Name: Anthony Gorski

13. Birthplace: Poland

MOTHER

14. Maiden name: Katherine Kozlowski

15. Birthplace: Poland

16. Informant: Joseph Gralewski

Address: 3615 Fairfield Rd. East Brooklyn Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-23-40 (month) (day) (year)

Cemetery or crematory: St. Stanislaus ~~Holy Rosary~~

Location: Odonnell St Ext

18. Funeral director: Wm. S. Fialkowski

Address: 2007 Eastern Ave

19. 7-20 (Date rec'd by registrar) 1940 L. A. Breit Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1940, at 4:15 M

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post-mortem examination ~~and that I last saw him alive on~~ 19

Immediate cause of death: Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: — — —

Of autopsy: — — —

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of 7/20/40

Where did injury occur? in Stony Creek (City or town) Greenland Beach (County) (State)

Injured at home, farm, industry, public place (where?): Stony Creek

Means of injury: drowning Injured at work? No

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md Date signed 7/20/40

Name of cemetery changed on authorization of undertaker in person.

7-24-40 AS

STATE OF MARYLAND—CERTIFICATE OF DEATH

07193

V. S. No. 1

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1. PLACE OF DEATH (931)

County Anne Arundel Registration Dist. No. 21

Village or City Round Bay, Md. No. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residance in city or town where daath occurrad 10 yrs. mos. ds. How long in U. S. If of foraign birth? yrs. mos. ds.

2. FULL NAME Barbara J. Gralley If U. S. Veteran, specify WAR

(a) Residence: No. Round Bay Md. St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX	4. COLOR OR RACE	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write tha word)
F	W	Widowed

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of: Charles Gralley

6. DATE OF BIRTH (month, day, and yaar): Nov. 7, 1861

7. AGE Years	Months	Days	If LESS than 1 day, hrs. or min.
78	8	23	

OCCUPATION

8. Trade, profession, or particular kind of work dona, as SPINNER, SAWYER, BOOKKEEPER, etc.: Housewife

9. Industry or businass in which work was dona, as SILK MILL, SAW MILL, BANK, etc.:

10. Date deceased last worked at this occupation (month and yaar):

11. Total time (years) spent in this occupation:

12. BIRTHPLACE (city or town) (State or country): Baltimore Md.

FATHER

13. NAME: Geo. Krantz

14. BIRTHPLACE (city or town) (State or country): Balto. Md.

MOTHER

15. MAIDEN NAME: Margaret Buckheimer

16. BIRTHPLACE (city or town) (State or country): Balto. Md.

17. INFORMANT: Mr. Geo. Gralley (Address) Round Bay

18. BURIAL, CREMATION, OR REMOVAL Place: Balto. Cem. Date: 7-6, 1940

19. UNDERTAKER: J. J. McCully (Address) 130 E. Fast Ave.

20. FILED: July 5, 1940 [illegible] Dep. Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July (Month) 2 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from August, 1939, to July 2, 1940

I last saw h[illegible] alive on July 2, 1940 death is said to have occurred on the date stated above, at 5:30 m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

	Date of onset
Chr. Myocarditis	
Other Contributory Causes of Importance: Senile psychosis	No. 40.

Name of operation: None Date of:

What test confirmed diagnosis? Clinical Was thara an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of Injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of Injury

Nature of injury

24. Was disaasa or injury in any way ralated to occupation of deceased? No

If so, specify

(Signad) Maurice F. Kaufman M. D.

(Address) 31 Smithsonian Ave.

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arterioselerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
AUG 5 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (468)

CERTIFICATE OF DEATH

Reg. Dist. No. 11 — 17194

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: U. S. Naval Hospital

Stay in hospital or inst. (yrs., or mos., or days): 1 mo., 17 days

Stay in this community (yrs., or mos., or days): 18 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 1025 N. Bentlou St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: World War

3. (a) FULL NAME: Frederick (none) HAMBRUCH

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Nanie A. Hambruch

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 12, 1885

8. AGE: Years	Months	Days	If less than one day
55	4	2	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)

10. Usual occupation: Machinist

11. Industry or business: U. S. Navy (Retired)

FATHER — 12. Name: Fredrick Hambruch

13. Birthplace: Germany

MOTHER — 14. Maiden name: Anna Hambruch

15. Birthplace: Germany

16. Informant: Mrs. Harry W. Miller (Sister)

Address: 107 N. Linden Ave., Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 1940 (month) (day) (year)

Cemetery or crematory: Parkwood National Cem

Location: Loch Raven - Baltimore, Md

18. Funeral director: Harry H. Wiltse

Address: 407 Edmondson Ave

19. July 14 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14, 1940 19 , at 5:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 1940 19 , to July 14, 1940 19 , and that I last saw h im alive on July 13th., 1940 19 .

Immediate cause of death	DURATION
Carcinoma, stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: Inoperable

Carcinoma, stomach

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

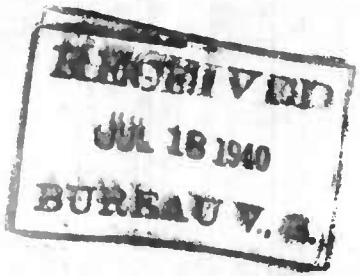
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. W. ALLEN, Commander (MC) USN
M. D. or other

Address Date signed


RECEIVED
JUL 18 1940
BUREAU V. R.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

07195

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
160 Green St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Ward No. 2
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 160 Green St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Cina Elizabeth Neal Harrington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

8 (b) Name of husband or wife John L. Harrington
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Oct 29th 1853

8. AGE: Years	Months	Days	If less than one day
86	8	7	____ hrs. ____ min.

9. Birthplace Town Point Md.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Butterbridge H. Neal
13. Birthplace Delaware
MOTHER 14. Maiden name Elinore Bradley
15. Birthplace Maryland
18. Informant Irene Harrington
Address 160 Green St. Annapolis Md
17. Burial Date thereof July 7th 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md.
18. Funeral director John M. Taylor
Address Annapolis Md.
19 July 7 19 40 J. J. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 6 1940, at 9 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1924 to July 6 1940, and that I last saw her alive on July 3 1940.

Immediate cause of death	DURATION
Gangrene foot	3 Mos
Due to Diabetes Mellitus	
Due to Cerebral Hem	16 yrs
Other conditions Arteriosclerosis	16 yrs

(Include pregnancy within 3 months of death)
Major findings:
Df operations
Dt autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. J. Murphy M. D. or other
Address Annapolis Md Date signed 7/6/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07196

Reg. Dist. No. 26

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Felicity Cove Shady Side
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County:
City or town: Lancaster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.:
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Edward W Hite Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

B (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 12 1923

8. AGE:

Years	Months	Days	If less than one day
16	6	26	hrs. min.

9. Birthplace: Lancaster, Pa
(Town, county, and state)
10. Usual occupation: Schoolboy
11. Industry or business:
FATHER 12. Name: Edward W Hite
13. Birthplace: Pa.
MOTHER 14. Maiden name: Myra D Ess
15. Birthplace: Pa.
16. Informant: Fred F Groff Inc.
Address: Lancaster, Pa.
17. Burial, cremation, or removal. Which?: Regional Date thereof: July 10 1940 (month) (day) (year)
Cemetery or crematory: —
Location: Lancaster, Pa.
18. Funeral director: Fred F Groff Inc.
Address: Lancaster, Pa.
19. July 9 1940 (Date rec'd by registrar) D. B. Dent. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 8, 1940, at 9 45 P.M

21. I CERTIFY that death occurred on the date above stated; ~~last attended deceased from~~ ~~to~~ ~~last saw deceased alive on~~ Post-mortem examination 19 40 19 19

Immediate cause of death: Drowning

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings: —

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 7/3/40
Where did injury occur? Chesapeake Bay (City or town) County of West River (County) (State)
Injured at home, farm, industry, public place (where?): West River - Chesapeake Bay
Means of injury: Drowning Injured at work? No

23. SIGNATURE: John M. Caffey, deputy medical examiner M. D. or other
Address: Annapolis, Md. Date signed: 7/9/40

RECEIVED
JUL 19 1940
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

CERTIFICATE OF DEATH

07197

Reg. Dist. No. 22

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH
County: Anne Arundel
City or town: Gambrills
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: — — —
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 36 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Gambrills Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR

3. (a) FULL NAME: Rachael Ann Howard

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widow

6 (b) Name of husband or wife: William P. Howard
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby. 17, 1863

8. AGE: Years: 77 Months: 4 Days: 28 If less than one day: hrs. min.

9. Birthplace: Prince Fredrick, Calvert Co., Md (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: own home

FATHER
12. Name: Benj. Robertson
13. Birthplace: Calvert County. Md

MOTHER
14. Maiden name: Ann Greason
15. Birthplace: Calvert County. Md.

16. Informant: Mrs. Lena Sharp.
Address: 4211 Wiltshire Ave Baltimore Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17th 40 (month) (day) (year)
Cemetery or crematory: Gambrills Md
Location: Gambrills Md.

18. Funeral director: Lloyd Lawer
Address: Laurel Md

19. July 15 1940 (Date rec'd by registrar) K. L. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 15. 1940, at 7.43 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1940, to July 14 1940, and that I last saw her alive on July 14 1940.

Immediate cause of death	DURATION
Coronary Occlusion	Sudden
Due to Arteriosclerosis	6 years
Due to Arterial Hypertension	6 years
Other conditions Chronic Endocarditis	18 yrs.

(Include pregnancy within 3 months of death)

Major findings: — — —
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide / Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury / Injured at work?

23. SIGNATURE: John M. Claffey M.D.
M. D. or other
Address: Annapolis Md Date signed 7/15/40

RECEIVED
AUG 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07198

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: xxxxxx
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 118 S. Caroline St.
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3.(a) FULL NAME: JOHN HUDSON

3.(b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	Single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1862

8. AGE: Years	Months	Days	If less than one day
78	Unknown		...hrs. ...min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: General
FATHER 12. Name: Henry Hudson, dead
FATHER 13. Birthplace: Virginia
MOTHER 14. Maiden name: Mary Branch
MOTHER 15. Birthplace: Virginia
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/5/40 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville
18. Funeral director: Supt
Address:
19. Aug 5 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27th, 1940 10:40 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 16th 1940, to July 27th 1940 and that I last saw h... im alive on July 27th 1940

Immediate cause of death	DURATION
Syphilis	
Due to	
Due to	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.
Autopsy results: ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----
Means of injury: ------ Injured at work?

23. SIGNATURE: Albert P. Winfrede M. D. or other
Address: Crownsville, Md. Date signed 7/29/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
SEP 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07199

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 months, 15 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 7 months, 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2627 Boone Street
(If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: JOHN JOHNSON #4

3. (b) Social Security Number: 218-10-5208 (Poss.)

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widowed

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): May 12, 1886

8. AGE: Years	Months	Days	If less than one day
54	2	10	..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Chauffeur

11. Industry or business: -------

FATHER
12. Name: Frank Johnson, dead
13. Birthplace: Maryland

MOTHER
14. Maiden name: Clara (Unknown) dead
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 25, 1940 (month) (day) (year)

Cemetery or crematory: Mt Calvary Cem

Location: A.A. Co.

18. Funeral director: Rayner Sanders

Address: 1412 E Preston St.

19. 7/23 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22nd 1940, at 5:10P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7th 1940, to July 22 1940 and that I last saw him alive on July 22nd 1940

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Lues	
Other conditions -------	

(Include pregnancy within 3 months of death)

Major findings of operations: ------

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -----

Means of injury Injured at work? -----

23. SIGNATURE: Joseph P. McBride M. D. or other

Address: Crownsville, Md Date signed: 7/22/40

RECEIVED
JUL 30 1940
BUREAU V. S.

Dr. Green

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

07200

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A. A.
City or town Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 215 Clay st.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County A. A.
City or town Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 215 Clay st
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

3. (a) FULL NAME Lawrence Columbus Johnson

3. (b) Social Security Number 220-03-1462

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	Colored	Single

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29 1911

8. AGE:

Years	Months	Days	If less than one day
28	11	27	hrs. min.

9. Birthplace Patrole, Md
(Town, county, and state)
10. Usual occupation Laborer
11. Industry or business
FATHER 12. Name Richard Johnson
13. Birthplace Prince Georges Co
MOTHER 14. Maiden name Josephine Carpenter
15. Birthplace Baltimore Co
18. Informant Josephine Johnson
Address 215 Clay St
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 29/940 (month) (day) (year)
Cemetery or crematory Bowlers Cemetary
Location Best Gate, A. A. Co.
18. Funeral director J. B. Johnson
Address Annapolis.
19. 7/28 1940 (Date rec'd by registrar) J. H. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 26 1940 at 4.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 1940 to July 26 1940
and that I last saw him alive on July 26 1940

	DURATION
Immediate cause of death	
Lobar Pneumonia	7 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Lawrence W. Greene, M.D.
M. D. or other
Address Annapolis Date signed 7/27/40

RECEIVED
AUG 5 1940
BUREAU V. S.

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (47D)

21

Reg. Dist. No.

07201

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Freetown (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: P.O. Glen Burnie
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) life

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md. (b) County Anne Arundel
(c) City or town Freetown (If outside city or town limits, write RURAL and give town)
(d) Street No. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Elizabeth Kelley

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex: female

5. Color or race: negro

6 (a) Single, married, widowed, or divorced: widowed

6 (b) Name of husband or wife John Kelley

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 12-29-1873

8. AGE: Years 66 | Months 6 | Days 27 | If less than one day hr. min.

9. Birthplace A. A. Co., Md. (Town, county, and state)

10. Usual occupation midwife

11. Industry or business

FATHER
12. Name Hezekiah Fisher
13. Birthplace Md.

MOTHER
14. Maiden Name Martha Owens
15. Birthplace Md.

16 (a) Informant Jane Spencer
(b) Address P.O. Glen Burnie, Md.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof 7-28-40 (month) (day) (year)
(c) Cemetery or crematory Marley Neck Cem.
Location A. A. Co., Md.

18 (a) Funeral director I. Brown
(b) Address Baltimore, Md.

19 (a) 7-26-40 (Date rec'd by registrar) (b) L. A. Brein Registrar

MEDICAL CERTIFICATION

20. Date of death July 26 1940, at 5 AM

21. I certify that death occurred on the date above stated; that I attended deceased from May 1938, to 7-26 1940, and that I last saw him alive on 7-25 1940.

Immediate cause of death	Duration
Pulmonary carcinoma	2 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature L. A. Brein, M.D. (M. D. or other)
Address Pasadena, Md. Date signed 7-26-40

RECEIVED
AUG 1 1940
BUREAU V. S

07202

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(172)

CERTIFICATE OF DEATH

Reg. Dist. No. ~~71~~ 20

1. PLACE OF DEATH:

County Anne Arundel

City or town near Mayo off Turkey Pt South River

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne Arundel

City or town Woodland Beach Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Irving C. Kendrick

3. (b) Social Security Number

4. Sex: male

5. Color or race: white

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Dorothy F. Kendrick

6(c) If alive, give age 41 years

7. Birth date of deceased (mo., day, yr.): Jany. 21. 1899

8. AGE: Years 41 Months 5 Days 11 If less than one day ___ hrs. ___ min.

9. Birthplace: Washington D.C. (Town, county and state)

10. Usual occupation: Truck driver

11. Industry or business: Construction

FATHER

12. Name: Joseph Kendrick

13. Birthplace: Maryland

MOTHER

14. Maiden name: Emily Hart

15. Birthplace: London, England

16. Informant: Mrs Cath. M. Clark

Address: 1520 Trinidad Ave N.E. Wash. D.C.

17. Removal (Burial, cremation, or removal. Which?) Date thereof 7-1-1940 (month) (day) (year)

Cemetery or crematory

Location: Wash D.C.

18. Funeral director: W W Chambers.

Address: 517-11 st, S.E.

19. 7-2 (Date rec'd by registrar) 1940 J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 2 1940, at 10 A M

21. I CERTIFY that death occurred on the date above stated; ~~Last attended deceased from~~ Post-mortem 19 examination 19 ~~and that I last saw h. x. alive on~~ July 2 1940

Immediate cause of death: Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: accident Date of June 29. 1940

Where did injury occur? near Mayo (City or town) AA (County) Md (State)

Injured at home, farm, industry, public place (where?) off Turkey Pt South River

Means of injury: over turned boat Injured at work? no

23. SIGNATURE John M. Claffy Deputy medical examiner M. D. or other

Address: Annapolis, Md Date signed 7/2/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

07203

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel County

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Jan. 4. 1938

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? Since Jan. 4. 1938

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1113 Mosher Str.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Martha Lewis

3.(b) Social Security Number:

4. Sex: f

5. Color or race: col.

6.(a) Single, married, widowed, or divorced: single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 27 Months: — Days: — If less than one day ..... hrs. ..... min.

9. Birthplace: Virginia
(Town, county, and state)

10. Usual occupation: home work

11. Industry or business:

FATHER
12. Name:
13. Birthplace:

MOTHER
14. Maiden name: unknown
15. Birthplace:

16. Informant: Crownsville State Hospital
Address: Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof ..... (month) (day) (year)

Cemetery or crematory:

Location: Shipped to Lynchburg Va

18. Funeral director: Charles H. Alexander
Address: 45 North West Street

19. 7/14 1940 J.J. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13. 1940 at 5:10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 4. 1938, to July 13 1940 and that I last saw her alive on July 13. 1940

Immediate cause of death: tuberculosis of both lungs

DURATION:

Due to:

Due to:

Other conditions: Schizophrenia (hebephr.)
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. L. Smithson M. D. or other

Address: Crownsville Date signed:

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07204

Reg. Dist. No. 27

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft Geo. G. Meade, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Station Hospital
How long in hospital or institution? 4 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Richard Eugene Lupp

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	W	-

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1940

8. AGE: Years	Months	Days	If less than one day
			4 hrs. 5 min.

9. Birthplace: Ft Geo G. Meade, Md.
(Town, county, and state)
10. Usual occupation: -
11. Industry or business: -

FATHER
12. Name: Eugene Luther Lupp
13. Birthplace: Aspers Penna.

MOTHER
14. Maiden name: Helen Marie Peters
15. Birthplace: Fairfield Penna.

16. Informant: Eugene Luther Lupp
Address: Ft. Geo. G. Meade, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 9, 1940 (month) (day) (year)
Cemetery or crematory: Ft Geo G. Meade, Md.
Location:

18. Funeral director: Post Quartermaster
Address: Ft Geo G Meade, Md.

19. July 7 1940 D.P.Card. Col. MC
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 7 1940 at 5.35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Toxemia (Eclampsia of mother) born by cesatean section	4 hrs
Due to	
Due to	
Other conditions	

(Includs pregnancy with.in 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Ft Geo G Meade, Md. Date signed:

RECEIVED
AUG 31 1940
BUREAU V. S.

07205

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

Reg. Dist. No. 26

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Deale, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: —
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Montgomery
City or town: Route #2 Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Silver Springs
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Fred. T. McAlister

3. (b) Social Security Number: 214-03-9378 (Poss.)

4. Sex: male
5. Color or race: white
6. (a) Single, married, widowed, or divorced: married
6 (b) Name of husband or ~~wife~~: Lena McAlister
6(c) If alive, give age: 33 years
7. Birth date of deceased (mo., day, yr.): Nov. 19, 1905
8. AGE: Years 34 Months 7 Days 26 If less than one day ___ hrs. ___ min.
9. Birthplace: Lincolnton, N.C. (Town, county, and state)
10. Usual occupation: Brick-layer
11. Industry or business: General Construction
FATHER 12. Name: Julius H. McAlister
13. Birthplace: Lincolnton, N.C.
MOTHER 14. Maiden name: Laura C. Schrum
15. Birthplace: Lincolnton, N.C.
16. Informant: Victor M. McAlister
Address: Silver Springs, Md.
17. transportation (Burial, cremation, or removal. Which?) Date thereof: July 17 1940 (month) (day) (year)
Cemetery or crematory
Location: Wash. D.C.
18. Funeral director: W. W. Chambers Co
Address: 1400 - Chapin St N.W. Wash D.C.
19. July 17. 1940 (Date rec'd by registrar) I. B. Dent Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 13 1940, at 8 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem examination and that I last saw him alive on July 17. 1940
Immediate cause of death: Drowning
Due to: fall from boat
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings: —
Of operations: —
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Accident Date of: 7/13/40
Where did injury occur? Chesapeake Bay near (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Deale, Md
Means of injury: fell over board Injured at work? no

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other
Address: Annapolis, Md Date signed: 7/17/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
BUREAU V. S.

STATE OF MARYLAND—CERTIFICATE OF DEATH

07206

(183)

1. PLACE OF DEATH

County Anne Arundel Registration Dist. No. 22

Village or City Odenton No. near Brogers Station St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. 1 ds. How long in U.S. if of foreign birth? yrs. mos. ds.

2. FULL NAME Catherine A. McPherson If U.S. Veteran specify WAR

(a) Residence: No. Odenton Md St., Ward.

(Usual place of abode) If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX female

4. COLOR OR RACE white

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) single

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Sept 11, 1929.

7. AGE Years 10 Months 10 Days — If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or perticular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. School.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Ill.

FATHER

13. NAME Jerry B. McPherson

14. BIRTHPLACE (city or town) (State or country) Ill.

MOTHER

15. MAIDEN NAME Roxey A. Thompson.

16. BIRTHPLACE (city or town) (State or country) Va.

17. INFORMANT (Address) Jerry B. McPherson Odenton Md.

18. BURIAL, CREMATION, OR REMOVAL

Place Laurent Date , 19

19. UNDERTAKER (Address) Chenoweth & Donovan 3615-17 Christopher Ave, Balto Md

20. FILED July 11, 1940 H. L. Jones Deputy Registrar

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH July 11 (Month) (Day) 1940 (Year)

22. I HEREBY CERTIFY, ~~That I attended deceased from~~ Post-mortem examination ~~Last saw [illegible] alive on~~ July 11, 1940; death is said to have occurred on the date stated above, at 5 20 p.m.

The **PRINCIPAL CAUSE OF DEATH** and related causes of importance were as follows:

	Date of onset
Drowning	

Other **Contributory Causes** of importance:

Name of operation — Date of —

Whet test confirmed diagnosis? — Was there an autopsy? no

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Accident Date of injury 7/11, 1940

Where did injury occur? water hole Bartons Sand pit (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE. on private property

Manner of injury Drowning

Nature of injury accidental

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed) John McClaffy Deputy Medical Examination M. D.

(Address) Annapolis Md

If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
Arteriosclerosis	*1915*
Chronic interstitial nephritis	*1921*
Cerebral hemorrhage	*July 5, 1927*
Other contributory causes of importance:	
Gallstones	*May 1, 1923*

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
Attack of epilepsy	*1 week ago*
Run over by street car	*1 week ago*
Peritonitis	*3 days ago*
Other contributory causes of importance:	
Gastroenteritis	*1 year*

RECEIVED
AUG 7 1940
BUREAU V. S.

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STANDARD CERTIFICATE OF DEATH

State File No. 07207

Registrar's No. 27

State of Maryland

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Ft Geo G Meade, Md (If outside city or town limits, write RURAL)
(c) Name of hospital or institution: Station Hospital (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 11 days (Specify whether years, months or days) In this community 11 days

2. USUAL RESIDENCE OF DECEASED:
(a) State Penna (b) County Delaware
(c) City or town Chester (If outside city or town limits, write RURAL)
(d) Street No. 2618 W. 6th St. (If rural, give location)
(e) If foreign born, how long in U. S. A.? - years.

3. (a) FULL NAME William Henry Moore
3. (b) If veteran, name war -
3. (c) Social Security No. -
4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced Single
6. (b) Name of husband or wife -
6. (c) Age of husband or wife if alive - years
7. Birth date of deceased December (Month) 19th (Day) 1919 (Year)
8. AGE: Years 20 Months 6 Days 19 If less than one day - hr. - min.
9. Birthplace Philadelphia (City, town, or county) Penna (State or foreign country)
10. Usual occupation Clerk
11. Industry or business Civilian Conservation Corps

MOTHER FATHER
12. Name Unknown
13. Birthplace Unknown (City, town, or county) (State or foreign country)
14. Maiden name Unknown
15. Birthplace Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature
(b) Address CCC Individual Record
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof July 9 (Month) (Day) 1940 (Year)
(c) Place; burial or cremation

18. (a) Signature of funeral director T. A. Hardesty & Son
(b) Address Galesville, Maryland

19. (a) July 8/40 (Date received local registrar) (b) D. P. CARD, Colonel, MC (Registrar)

MEDICAL CERTIFICATION

20. Date of death: Month July day 8th year 1940 hour 6 minute 30 AM
21. I hereby certify that I attended the deceased from June 27th, 1940 to July 8, 1940 that I last saw him alive on July 8, 1940 and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death Status Epilepticus	1 hr
Due to Syphilis, cerebro spinal, congenital	20 yrs
Due to Pulmonary Edema due to Epilepticus	15 min
Other conditions - (Include pregnancy within 3 months of death)	

Major findings:
Of operations -
Of autopsy Pulmonary edema and acute cardiac dilatation, right.

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) -
(b) Date of occurrence -
(c) Where did injury occur? - (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? -
While at work? - (Specify type of place) (e) Means of injury -

23. Signature JACK LASNER, 1st Lt, Med-Res, (M.D. or other)
Address Ft Geo G Meade, Md Date signed 7/8/40

8-6917 U. S. GOVERNMENT PRINTING OFFICE 16—13493

RECEIVED
JUL 26 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

07208

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md.
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 58 State Circle
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Grace Howard Morton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife James P. Morton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 14th 1883

8. AGE: Years	Months	Days	If less than one day
57	4	1	..... hrs. ..... min.

9. Birthplace Annapolis Md.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business
FATHER 12. Name Thomas B. Howard
13. Birthplace Ill.
MOTHER 14. Maiden name Ann C. Claude
15. Birthplace Annapolis Md.
16. Informant Mrs Douglas Howard
Address 58 State Circle, Annapolis Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17th 1940 (month) (day) (year)
Cemetery or crematory Naval Academy
Location Annapolis Md.
18. Funeral director John M. Taylor
Address Annapolis Md.
19. 7 16 1940 J M Murphy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1940 at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15th 1940, to July 15 1940 and that I last saw h...er alive on July 15 1940

Immediate cause of death	DURATION
Cerebral Hemorrhage (Apoplexy)	2 hrs.
Due to Chronic Hypertension	Unknown
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE O B Morrison Jr. M. D. or Other
Address Annapolis, Md. Date signed July 15 1940
(U.S. Naval Academy)

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 5 1940
U. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (185)

07209

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County A.A.
City or town Eastport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Spa Creek
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 4 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A.A.
City or town Eastport Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Sarles Boat House
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR none

3. (a) FULL NAME Donald Sterling Moseman

3. (b) Social Security Number 108-03-2210

4. Sex M
5. Color or race W
6. (a) Single, married, widowed, or divorced Married
6 (b) Name of husband or wife Katerine V. Moseman
6(c) If alive, give age 22 years
7. Birth date of deceased (mo., day, yr.) July 3 1918
8. AGE: Years 22 Months Days 22 If less than one day hrs. min.
9. Birthplace New York (Town, county, and state)
10. Usual occupation Printer
11. Industry or business
FATHER 12. Name Frank Moseman
13. Birthplace Unknown
MOTHER 14. Maiden name Unknown
15. Birthplace Unknown
16. Informant Katherine V. Moseman
Address Eastport Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 31 1940 (month) (day) (year)
Cemetery or crematory Unknown
Location Ozone Park Long Island N. Y.
18. Funeral director B.L.Hopping
Address Annapolis, Md.
19. July 29th 1940. (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 28 1940, at 8 15 p.M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post-mortem to examination and that I last saw him alive on July 28 1940.
Immediate cause of death Drowning
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations —
Of autopsy —

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 7/28/40
Where did injury occur? Eastport (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Spa Creek
Means of injury Drowning Injured at work? no

23. SIGNATURE John M. Claffey Deputy medical examiner M. D. or other
Address Annapolis, Md. Date signed 7/29/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

07210

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs. 6 mos. 16 days.

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 22 yrs. 6 mos. 16 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Harford

City or town: Unknown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: Unknown

3. (a) FULL NAME: JAMES (WESLEY) MURRAY

3. (b) Social Security Number: Unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	married

6.(b) Name of husband or wife: Unknown

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1888 ?

8. AGE:

Years	Months	Days	If less than one day
52	Unknown		..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business: -----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Date thereof: 7-29-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt.

Address:

19. July 29 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22nd 1940 at 2:50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6th 1918, to July 22nd 1940 and that I last saw him alive on July 22nd 1940

Immediate cause of death	DURATION
General arteriosclerosis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ----- Date of op.

Autopsy results: ----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury: Injured at work? -------

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 7/22/40

RECEIVED
AUG 5 1940
BUREAU V. S.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

(165)

Registered No. 07211

F ~~[illegible]~~

1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address 10 – 4th Ave.

(c) Hospital or institution: Brooklyn Park, A.A. Co.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State Md (b) County Anne Arundel

(c) City or town Brooklyn Park
(If outside city or town limits, write RURAL and give town)

(d) Street No. 10 – 4th Ave
(If rural give location)

(e) If foreign born, how long in U. S. A.? ..... years

3 (a) **FULL NAME** Mary Preston Nock

3 (b) If veteran, name war

3 (c) Social Security Account No.

4. Sex Female

5. Color or race White

6 (a) Single, married, widowed, or divorced. —

6 (b) Name of husband or wife Preston L. Nock

6 (c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 7 – 1940

8. **AGE:** Years | Months 1 | Days 15 | If less than one day ..... hr. ..... min.

9. Birthplace Md. Gen. Hospital
(Town, county, and state)

10. Usual Occupation —

11. Industry or business —

FATHER
12. Name Preston L. Nock
13. Birthplace Temperance Hill, Va

MOTHER
14. Maiden Name Mary Marie Melvin
15. Birthplace Pocomoke Md.

16 (a) Informant Preston L. Nock

(b) Address 10 – 4th ave – Brooklyn Pk –

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 25-40 (month) (day) (year)

(c) Cemetery or crematory

Location Pocomoke Md.

18 (a) Funeral director Holloway & Co Walter R. Holloway

(b) Address 520 E. Church St. Salisbury Md.

19 (a) (Date rec'd by registrar) (b) Huntington Williams, M.D. (Registrar)

JUL 24 1940

VS 6

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-22- 1940, at 2:50 P. M

21. I HEREBY CERTIFY, That I took charge of the remains described above, held an Autopsy (Autopsy or Inquiry) thereon and from the evidence obtained by said Autopsy (Autopsy or Inquiry) find that said deceased came to her death on the day stated above.

Immediate cause of death Drowning

Due to

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide homocide

(b) Date of occurrence 7-22-40

(c) Where did injury occur? Anne Arundel Co. Md (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? Home (Specify type of place) While at work? —

(e) Means of injury Bath tub submersion

23. Signature Howard J. Walden M.D.
Medical Examiner.

Date signed 7-24-40

THE MORGUE

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157)

07212

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis, Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days) 6 Days

Stay in this community (yrs., or mos., or days) 6Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Harwood, Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Rural
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Truman Burwell Norfolk

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 21 1940

8. AGE:

Years	Months	Days	If less than one day
	1	4	hrs. min.

9. Birthplace Harwood Maryland
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name James O Norfolk
13. Birthplace Maryland

MOTHER
14. Maiden name Evlyn Stallings
15. Birthplace Maryland

16. Informant James O Norfolk
Address Harwood Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26 1940 (month) (day) (year)

Cemetery or crematory Mt.Zion

Location Mt. Zion Maryland

18. Funeral director B.L.Hopping
Address Annapolis, Md.

19. 7 26 1940 (Date rec'd by registrar) J. [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 25 1940, at 11 30 am M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1940, to July 25 1940, and that I last saw her alive on July 25 1940.

Immediate cause of death

	DURATION
Hemorrhage secondary	Since birth
Due to Possible hemophilia	
Due to Hypertrophic Pyloric Stenosis	Since birth
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Annapolis Md Date signed July 25/40

VS A15 (T) (I) (M) (C) (P)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-2)

CERTIFICATE OF DEATH

07213

Reg. Dist. No. 24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 14 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 1 month, 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Libertytown

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown

(If rural, give LOCATION)

2.(a) If veteran, name war: ---

3. (a) FULL NAME: ABRAHAM ORM

3. (b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	black	widowed

6.(b) Name of husband or wife: (Unknown)

6.(c) If alive, give age ? years

7. Birth date of deceased (mo., day, yr.): 1863

8. AGE: Years	Months	Days	If less than one day
77	Unknown		... hrs. ... min.

9. Birthplace: Unknown (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER 12. Name: Edward Orm

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Eliza (Unknown)

MOTHER 15. Birthplace: Unknown

18. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) Burial Date thereof 7-29-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Dept

Address:

19. (Date rec'd by registrar) July 29 1940 E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 29th 1940 at 8:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15th 1940 to July 29th 1940 and that I last saw h...im...alive on July 29th 1940

Immediate cause of death	DURATION
Chronic endocarditis	
Due to	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op.

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: --- Date of

Where did injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work? ---

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed 7/29/40

RECEIVED
AUG 5 1940
BUREAU V. S.

07214

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville State Hospital
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 yrs. 1 mos. 21 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 27 yrs. 1 mos. 21 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Frederick

City or town: Montevue Asylum
(If outside city or town limits, write RURAL and give nearest town)

Street No.: -------
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3. (a) FULL NAME: IDA PALMER

3. (b) Social Security Number: ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	single

6.(b) Name of husband or wife: -------

B.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1883

8. AGE:

Years	Months	Days	If less than one day
57	Unknown		....hrs. ....min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Cook

11. Industry or business: ----

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial
(Burial, cremation, or removal. Which?) Date thereof: 7-9-40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

18. Funeral director: Supt

Address

19. July 9 1940 (Date rec'd by registrar) E. F. Joyce DL Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 4th 1940, at 6:30P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13th 1913, to July 4th 1940 and that I last saw her alive on July 4th 1940

Immediate cause of death	DURATION
Cerebral hemorrhage	
Due to	
Due to	
Other conditions: ------	

(Include pregnancy within 3 months of death)

Major findings of operations: -----

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ----- Date of

Where did injury occur? ------ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -------

Means of injury Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed: 7/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (106a)

CERTIFICATE OF DEATH

07215

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A.A.

City or town Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 80 Prince George Street

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 84 Years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapolis, Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 80 Prince Geo (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME William C. Parkinson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6 (b) Name of husband or wife Mary A. Pakinson

6(c) If alive, give age 74 years

7. Birth date of deceased (mo., day, yr.) Jan 23 1856

8. AGE: Years	Months	Days	If less than one day
84	6	21	hrs. min.

9. Birthplace Annapols, Md. (Town, county, and state)

10. Usual occupation Waterman

11. Industry or business

FATHER 12. Name Joseph Parkinson

FATHER 13. Birthplace Annapolis

MOTHER 14. Maiden name Susan Gardner

MOTHER 15. Birthplace Annapolis

16. Informant Mary A. Parkinson

Address 80 Prince Geo Street

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 1940 (month) (day) (year)

Cemetery or crematory Cedar Bluff

Location Annapolis, Md.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. 7/17/40 (Date rec'd by registrar) J J Murphy (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH July 14 1940, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from May 1 1940, to July 14 1940, and that I last saw him alive on July 14 1940

	DURATION
Immediate cause of death Myocardial Insufficiency	2 hrs
Due to Acute Bronchitis	2 hrs
Due to Herpes Zoster	6 mo
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. Willis Martin M.D. M. D. or other

Address Annapolis Md Date signed 7/16/40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93a)

CERTIFICATE OF DEATH

Reg. Dist. No. 20 07216

1. PLACE OF DEATH: a a

County

City or town Tracey's Landing

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County a a

City or town Friendship Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

3. (a) FULL NAME J Luther Phipps

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced W

6 (b) Name of husband or wife Mammie Smith

6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 8, 1880

8. AGE: Years 60 Months 1 Days 26 If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Wm Phipps

13. Birthplace Md

MOTHER 14. Maiden name Margaret Hardesty

15. Birthplace Md

16. Informant Clarence Phipps

Address Ewing Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/6/40 (month) (day) (year)

Cemetery or crematory Friendships.

Location Md

16. Funeral director Robert Wood

Address Friendships. Md

19. 7/4/40 (Date rec'd by registrar) 19 W. R. Claytor Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7/4 1940, at 4A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from #1 1940, to 7/4 1940, and that I last saw him alive on 7/2 1940.

Immediate cause of death Acute myocarditis

DURATION 1 wk

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to esternal causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H M Ward M. D. or other

Address Ewing Md Date signed 7/4/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-8)

CERTIFICATE OF DEATH

07217

Reg. Dist. No. 20

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: A-Ar.

City or town: Drury

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): Life

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Drury Md Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: no

3. (a) FULL NAME: George H. Pumphrey

3. (b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Mal	Col	Married

B (b) Name of wife: Emily Pumphy

6(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): Aug 20 1882

8. AGE:

Years	Months	Days	If less than one day
57	11	1	hrs. min.

9. Birthplace: Bristol Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Unknown

13. Birthplace: Unknown

MOTHER

14. Maiden name: Sofelia Butler

15. Birthplace: Unknown

16. Informant: Sarah Sellman

Address: Drury

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 1940 (month) (day) (year)

Cemetery or crematory: Moses

Location: Drury

18. Funeral director: G. A. Hardesty & Son

Address: Gabsville Md

19. 7/24 1940 (Date rec'd by registrar) W. P. Clayton Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 21 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1938 to July 21 1940, and that I last saw him alive on July 20 1940.

Immediate cause of death	DURATION
Lobar pneumonia + Arteriosclerosis	1938 to 1940
Due to	
Due to	
Other conditions: Cerebral Hemorrhage	5 days

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: no

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Ramsay Sasscer M. D. or other

Address: Upper Marlboro Md Date signed 7/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

30-2

07218

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 7 mos. 11 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 7 mos. 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: —

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 613 Greenwillow St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: George Reynolds

3. (b) Social Security Number: —

4. Sex: Male

5. Color or race: Black

6.(a) Single, married, widowed, or divorced: Separated

6.(b) Name of ~~husband or~~ wife: Unknown

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): 1873?

8. AGE: Years: 67? Months: ? Days: ? If less than one day: ..... hrs. ..... min.

9. Birthplace: Georgia
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER
12. Name: Walker Reynolds
13. Birthplace: Georgia

MOTHER
14. Maiden name: Clara ?
15. Birthplace: Georgia

16. Informant: Hospital Records

Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 24 1940 (month) (day) (year)

Cemetery or crematory: Mt. ~~Calvary~~ Auburn Cemetery

Location: ~~Anne Arundel~~ Baltimore City County

18. Funeral director: William A. Jackson

Address: 916 Pennsylvania Ave. Balt

19. July 21 1940 (Date rec'd by registrar) E. Fletcher Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1940, at 4:00 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 29 1939, to July 20, 1940 and that I last saw him alive on July 20, 1940

Immediate cause of death: Syphilis — DURATION: Unknown

Due to:

Due to:

Other conditions: Arteriosclerosis — Unknown

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed:

RECEIVED
JUL 28 [illegible]
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-B)

07219

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:

County Anne Arundel

City or town Linthicum Heights (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Maple Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md County Anne Arundel

City or town Linthicum Heights Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. Maple Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME George Howell Rogers

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Emma Jean Rogers

6(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.): Jan 14 1887

8. AGE: Years 53 Months 6 Days 10 If less than one day ___ hrs. ___ min.

9. Birthplace: Baltimore Md (Town, county, and state)

10. Usual occupation: Heating Business

11. Industry or business: Sell

FATHER 12. Name: Albert H Rogers

13. Birthplace: Baltimore Md

MOTHER 14. Maiden name: Emma Zellers

15. Birthplace: Md

16. Informant: Mrs Frank Firth

Address: Springfield Mass

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 26 1940 (month) (day) (year)

Cemetery or crematory: London Park

Location: Baltimore Md

18. Funeral director: William Cook

Address: Baltimore Md

19. 25 July 1940 (Date rec'd by registrar) Lawrence Woodruff Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 24 1940, at 9 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 21 1940, to July 24 1940, and that I last saw him alive on July 23 1940.

Immediate cause of death: Uraemia — DURATION about one week

Due to: Chr Nephritis + Hypertension — many years

Due to: Chr Myocarditis associated

Other conditions: Cardio-renal disease

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: T W Reown M D (M. D. or other)

Address: 1938 Linden Ave Baltimore Md — Date signed July 24/40

RECEIVED
JUL 29 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9)

07220

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Homewood Rural near Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 1109 Popular Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 8 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County A.A.

City or town Homewood near Annapolis Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1109 Popular Ave
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Helen M. Rogers

3. (b) Social Security Number None.

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Single

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 7 1939

8. AGE: Years | Months 8 | Days 15 | If less than one day hrs. min.

9. Birthplace Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Milton E. Rogers
13. Birthplace Maryland

MOTHER
14. Maiden name Margaret A. Skinner
15. Birthplace Maryland

16. Informant Milton E. Rogers

Address 1109 Popular Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 24 1940 (month) (day) (year)

Cemetery or crematory Quaker Cemetery

Location Galesville Md.

18. Funeral director B.L.Hopping

Address Annapolis, Md.

19. 7 23 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 22 1940, at 12 30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9 1940, to July 22 1940, and that I last saw her alive on July 22 1940.

Immediate cause of death Bronchitis Aspiration Pneumonia.

Due to Whooping Cough.

Due to Cleft palate and poor aspiration

Other conditions Premature
(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 2 wks. Since July 5/40

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Oliver Purvis M. D. or other

Address Annapolis Md Date signed July 23/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A16

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (93d) Reg. Dist. No. 21

CERTIFICATE OF DEATH

07221

1. PLACE OF DEATH:

(a) County Anne Arundel

(b) City or town Paradise Beach (If outside city or town limits, write RURAL and give town)

(c) Street address, hospital, or institution: P.O. Pasadena, Md.

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in this community (yrs., mos., or days) 2 days

2. HOME (USUAL RESIDENCE) OF DECEASED:

(a) State Pa. (b) County Snyder ✓

(c) City or town Shamokan Dam (If outside city or town limits, write RURAL and give town)

(d) Street No. (If rural give location)

(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME: Harry Albright Schuck

3 (b) If veteran, name war

3 (c) Social Security No.

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
male	white	married

6 (b) Name of husband or wife Mary Emma Schuck

6. (c) If alive, give age 56 years

7. Birth date of deceased (mo., day, yr.) Apr. 12, 1869

8. AGE: Years	Months	Days	If less than one day
71	3	19	hr. min.

9. Birthplace Middleburg, Pa. (Town, county, and state)

10. Usual occupation train dispatcher

11. Industry or business (retired)

FATHER

12. Name John B. Schuck

13. Birthplace Pa.

MOTHER

14. Maiden Name Susan Hummel

15. Birthplace Pa

16 (a) Informant Mary E. Schuck

(b) Address Shamokan Dam, Pa.

17 (a) burial (Burial, cremation, or removal) (b) Date thereof Aug. 3 1940 (month) (day) (year)

(c) Cemetery or crematory

Location Shamokan Dam, Pa.

18 (a) Funeral director Wm. J. Tickner

(b) Address Baltimore, Md.

19 (a) 7-31-40 (Date rec'd by registrar) (b) L. A. Brait Registrar

MEDICAL CERTIFICATION

20. Date of death July 31 1940, at 9.45 PM

21. I certify that death occurred on the date above stated; that I attended deceased from 19 , to 19 , and that I last saw him alive on 7-31 1940

Immediate cause of death	Duration
Acute cardiac dilatation	1 hour
Due to Chronic myocarditis	indefin.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Underlins the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?

(e) Means of injury

23. Signature L. A. Brait, M.D.

Address Pasadena, Md. M. D. or other

Date signed 7-31-40

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30B)

CERTIFICATE OF DEATH

07222

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 months, 22 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 11 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Queen Anne's

City or town: Queenstown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: -----

3. (a) FULL NAME: JOHN SCOTT

3. (b) Social Security Number: --------

4. Sex: Male

5. Color or race: black

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Ella Scott

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1907

8. AGE: Years: 33 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: -----

FATHER
12. Name: George W. Scott
13. Birthplace: Maryland

MOTHER
14. Maiden name: Annie Anderson
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried
(Burial, cremation, or removal. Which?)
Date thereof: July 26, 1940
(month) (day) (year)

Cemetery or crematory: Gracesonville Cemetery

Location: Gracesonville, Maryland

18. Funeral director: Annie W. Edding
Address: Centreville, Maryland

19. 7-23-1940
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22nd 1940, at 11:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 31st 1939, to July 22 1940 and that I last saw him alive on July 22nd 1940

Immediate cause of death: General paralysis of the insane

DURATION

Due to:

Due to: Lues

Other conditions: -----
(Include pregnancy within 3 months of death)

Major findings of operations: -------

Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------ Date of

Where did injury occur? ------
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?): ------

Means of injury: Injured at work? ------

23. SIGNATURE: [signature]
M. D. or other

Address: Crownsville, Md. Date signed: 7/22/40

VS A15 (T) MARGIN RESERVED FOR BINDING (M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 6 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (836)

CERTIFICATE OF DEATH

07223

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A.A.
City or town Ferndale (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Fifth Ave
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 16 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County A.A.
City or town Ferndale Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Fifth Ave
(If rural give LOCATION)
2(a) IF YETERAN, NAME WAR None

3. (a) FULL NAME Ella Rhoda Stalliings

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
F	W	Married

8 (b) Name of husband or wife Clarence S Stallings
6(c) If alive, give age 82 years

7. Birth date of deceased (mo., day, yr.) Dec 27 1864

8. AGE: Years	Months	Days	If less than one day
75	6	18	hrs. min.

9. Birthplace Maryland (Town, county, and state)
10. Usual occupation House Wife
11. Industry or business

FATHER
12. Name Louis Duvall Lewis
13. Birthplace Maryland

MOTHER
14. Maiden name Emily Carrick
15. Birthplace Maryland

16. Informant Virgina Smith
Address Ferndale Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 17 1940 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Md

18. Funeral director B.L.Hopping
Address Annapolis, Md.

19. July 15 1940 (Date rec'd by registrar) McDeallas Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 15 1940 at 12 30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1940, to July 15 1940, and that I last saw h-- alive on July 19 1940.

	DURATION
Immediate cause of death Hemorrhage in the Brain	12 hours
Due to Arterio Sclerosis & Hypertension	2 years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations None.
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James S. Bielinglos M. D.
M. D. or other
Address Glen Burnie, Md Date signed July 13, 1940

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

07224

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A.A.

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 153 King Geo

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 2 Years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Annapolis Ward No.:
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 153 Prince Geo Street
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: William Albert Stewart

3. (b) Social Security Number:

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 21 1869

8. AGE: Years	Months	Days	If less than one day
71		13	hrs. min.

9. Birthplace: Annapolis
(Town, county, and state)

10. Usual occupation: Printer Retired

11. Industry or business:

FATHER
12. Name: William H. Stewart
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Austin
15. Birthplace: Annapolis

16. Informant: Ida E. Oliver

Address: 153 Prince Geo Street

17. Burial
(Burial, cremation, or removal. Which?)

Date thereof: July 13 1940
(month) (day) (year)

Cemetery or crematory: St Annes

Location: Annapolis, Md.

18. Funeral director: B.L.Hopping

Address: Annapolis, Md.

19. July 13 1940 J. J. Murphy
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1940, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1940 to July 10 1940, and that I last saw h in alive on July 10 1940.

Immediate cause of death	DURATION
Myocarditis & Myocardial Insufficiency	1939
Due to Arteriosclerosis	unknown
Due to Hypertension	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George C. Basil
M. D. or other

Address: Annapolis Md Date signed: 7-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 23 1940
BUREAU V. S.

07225

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a - a -

City or town: Annapolis Md.

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 10. Monument Street

Stay in hospital or inst. (yrs., or mos., or days): No

Stay in this community (yrs., or mos., or days): 75 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: a - a -

City or town: Annapolis Md Ward No. 4

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: No 10 Monument St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: George Washington Stuart.

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: Col

6. (a) Single, married, widowed, or divorced: Widower

6 (b) Name of husband or wife: Maniee Stuart

dead.

6(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 22. 1865

8. AGE: Years: 75 Months: 4 Days: 27. If less than one day: — hrs. — min.

9. Birthplace: Annapolis Md. (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: Day Laborer

FATHER

12. Name: Unknown

13. Birthplace: Unknown.

MOTHER

14. Maiden name: Unknown

15. Birthplace: Unknown.

16. Informant: Mrs Edna Brown.

Address: 10 Monument Street

17. St Ann. Cemt. (Burial, cremation, or removal. Which?) Date thereof: 7. 23. 1940 (month) (day) (year)

Cemetery or crematory: St Ann Cemt.

Location: Annapolis Md.

18. Funeral director: E. H. B. Parker.

Address: 47 Washington Street

19. 7 22 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20th 1940, at 3:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 18th 1940, to July 20th 1940, and that I last saw him alive on July 20th 1941

Immediate cause of death: Cerebral Apoplexy — DURATION: 2 days.

Due to: Arterio Sclerosis Hypertension — 1 yr.

Due to:

Other conditions: none

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other

Address: 110 - Clay St, Annapolis, Md. Date signed: 7/22/40

Dr Richardson

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131a)

07226

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Cor. Jessups Rd + Fifth Ave
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 21 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A
City or town: Odenton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Cor. Jessups Rd. + Fifth Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Ada Anna Mary Swails

3. (b) Social Security Number: None

4. Sex: female
5. Color or race: White
6. (a) Single, married, widowed, or divorced: married
B (b) Name of husband or wife: James N. Swails
6(c) If alive, give age: 58 years
7. Birth date of deceased (mo., day, yr.): Sept. 16, 1878

8. AGE: Years: 61 Months: 9 Days: 24 If less than one day: hrs. min.

9. Birthplace: St. Mary's County (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER
12. Name: James Gatton
13. Birthplace: St Mary's
MOTHER
14. Maiden name: Agnes M. Buckler
15. Birthplace: St. Mary's County
16. Informant: James N. Swails
Address: Odenton. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof July 13/40 (month) (day) (year)
Cemetery or crematory: St Mary's
Location: Annapolis
18. Funeral director: B. L. Hopping
Address: Annapolis. Md.
19. July 11 1940 (Date rec'd by registrar) H. L. Jones Deputy Registrar Lodge

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1940, at 2 P.M. 15
21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem to examination ~~and that I last saw b~~ alive on July 10 1940

Immediate cause of death	DURATION
Cardio-renal asthma	sudden
Due to Cardio-renal disease	4 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations — —
Of autopsy — —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: John M. Claffy Deputy Medical Examiner M. D. or other
Address: Annapolis Md. Date signed 7/10/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(M) (I) (T)

RECEIVED
AUG 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

07227

CERTIFICATE OF DEATH

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Weems Creek
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Weems Creek
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Baby Taylor

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 20th 1940

8. AGE: Years — Months — Days — If less than one day: hrs. min.

9. Birthplace: Weems Creek (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Daniel C. Taylor Jr.
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Thelma Smith
15. Birthplace: A. A. Co. Md

16. Informant: Daniel C. Taylor Jr.
Address: Weems Creek R.F.D. Md.

17. Rural (Burial, cremation, or removal. Which?) Date thereof July 20 1940 (month) (day) (year)

Cemetery or crematory: St Annes
Location: Annapolis Md.

18. Funeral director: John M. Taylor
Address: Annapolis Md.

19. July 20 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 20 1940 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1940 to July 20 1940 and that I last saw h[illegible] alive on July 20 1940

Immediate cause of death: Premature operation

DURATION: Minutes

Due to: placenta

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. Willis Martin M. D.
M. D. or other

Address: Annapolis Md. Date signed 7/20/40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-E

CERTIFICATE OF DEATH

07228

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Emergency Hospital
Stay in hospital or Insf. (yrs., or mos., or days): 0
Stay in this community (yrs., or mos., or days): 0

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severna Park Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: near Mays Corner
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: John W. Teel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6 (b) Name of husband or wife: Mary Teel
6(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): Oct 1869

8. AGE:

Years	Months	Days	If less than one day
70	10		hrs. min.

9. Birthplace: Austria (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Truck farming
FATHER 12. Name: not known
13. Birthplace: —
MOTHER 14. Maiden name: not known
15. Birthplace:
16. Informant: Elizabeth Teel
Address: Severna Park
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-18-40 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Annapolis Rd.
18. Funeral director: J. F. McCarthy
Address: 130 E. Forth Ave.
19. July 16 1940 (Date rec'd by registrar) Mae Talbert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 14 1940, at 10 P. M.
21. I CERTIFY that death occurred on the date above stated: Post-mortem examination.
July 14 1940

Immediate cause of death	Crushed chest.	
	Multiple Fractures of ribs	
Due to	Internal injuries.	
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings:
Of operations: no
Of autopsy: no

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide? Hit under investigation Date of 7/14/40
Where did injury occur? near Severn Park (City or town) A.A. (County) Md (State)
Injured at home, farm, industry, public place (where?) Ritchie Highway
Means of injury Automobile Hit and run driver Injured at work?

23. SIGNATURE: John M. Claffy Deputy medical examiner M. D. or other
Address: Annapolis, Md. Date signed 7/14/40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

07229

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Eastport Md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 325 W. Burnside St.

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 325 W. Burnside St

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Laura Ellen Thomas.

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: James Thomas

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept 7th 1881

8. AGE: Years: 59 Months: 10 Days: 29 If less than one day: hrs. min.

9. Birthplace: Cambridge Md (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business:

FATHER 12. Name: Calop H. Figgs

FATHER 13. Birthplace: Cambridge Md.

MOTHER 14. Maiden name: Susan Wheeler

MOTHER 15. Birthplace: Cambridge Md.

16. Informant: James Thomas

Address: E. Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 8th 1940 (month) (day) (year)

Cemetery or crematory: Edwards Chapel

Location: Camporole A A Co Md.

18. Funeral director: John M. Taylor

Address: Annapolis Md.

19. July 7 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6 1940 at 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that ~~[illegible]~~ Post mortem to examination July 6. 1940

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to Arterio-sclerosis	Not known
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) — (County) — (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE: John M. Cleffy Deputy Medical examiner M. D. or other

Address: Annapolis. Md Date signed 7/7/40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (830)

07230

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 22 Market Space
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: John R. Thompson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feby 29th 1872

8. AGE: Years	Months	Days	If less than one day
68	5	26	hrs. min.

9. Birthplace: Annapolis Md
(Town, county, and state)
10. Usual occupation: None
11. Industry or business:
MOTHER FATHER
12. Name: John Thompson
13. Birthplace: Annapolis Md
MOTHER
14. Maiden name: Elizabeth Ebury
15. Birthplace: Annapolis Md
16. Informant: Mrs Edward Burtis
Address: 22 Market St. Annapolis Md
17. Burial (Burial, cremation, or removal? Which?) Date thereof: July 29th 1940 (month) (day) (year)
Cemetery or crematory: St Anns
Location: Annapolis Md
18. Funeral director: John M. Sayler
Address: Annapolis Md.
19. July 29th 1940 (Date rec'd by registrar) J. Murray Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 27 1940 at 12 10 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
P.M. Post. Mortem Examination
to 19 ; that I last saw deceased alive on 19

Immediate cause of death	DURATION
Cerebral Hemorrhage	sudden
Due to: Arterio-sclerosis	5 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: John M. Duffy Deputy Medical Examiner
M. D. or other
Address: Annapolis Md Date signed: 7/27/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

07231

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: A. A.

City or town: Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 16 Lafayette Ave.

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Annapolis Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: 16 Lafayette Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Jacob Tillman

3. (b) Social Security Number: none

4. Sex: Male

5. Color or race: Colored

6. (a) Single, married, widowed, or divorced: married

6 (b) Name of husband or wife: Florence Tillman

6(c) If alive, give age: 68 years

7. Birth date of deceased (mo., day, yr.): Jan 10 1865

8. AGE: Years: 75 Months: 6 Days: 12 If less than one day: hrs. min.

9. Birthplace: Skidmore (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER

12. Name: Jacob Tillman

13. Birthplace: Skidmore

MOTHER

14. Maiden name: Martha Tillman

15. Birthplace: A. A.

16. Informant: Florence Tillman

Address: 16 Lafayette Ave.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7 24 40 (month) (day) (year)

Cemetery or crematory: Bewer Hill

Location: Annapolis Md.

18. Funeral director: J. B. Johnson

Address: Annapolis

19. 7 22 1940 (Date rec'd by registrar) J. J. Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 22 1940, at 1:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Post. mortem examination, July 22 1940

Immediate cause of death: Acute dilatation of heart — DURATION: sudden

Due to: Cardio-renal disease — 2 years

Due to: Arterio-sclerosis — ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations: —

Of autopsy: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of: —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: — Injured at work? —

23. SIGNATURE: John M. Claffy Deputy Medical Examiner M. D. ~~or other~~

Address: Annapolis Md. Date signed: 7/22/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

07232

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: A.A.

City or town: Annapolis
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Emergency Hospital

Stay in hospital or inst. (yrs., or mos., or days): 3 Days

Stay in this community (yrs., or mos., or days): 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: A.A.

City or town: Crownsville Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Rural
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: None

3. (a) FULL NAME: Richard A. Walker

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
M	W	Widowed

B (b) Name of husband or wife: Sallie H. Walker

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): May 29 1852

8. AGE: Years	Months	Days	If less than one day
88	1	21	____ hrs. ____ min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: William E. Walker
13. Birthplace: Maryland

MOTHER
14. Maiden name: Mary E. Alvey
15. Birthplace: Maryland

16. Informant: Albert Walker
Address: Crownsville, Md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof (month) (day) (year) July 22 1940

Cemetery or crematory: Methodist

Location: Davidsonville Md.

18. Funeral director: B.L. Hopping
Address: Annapolis, Md.

19. (Date rec'd by registrar) 7-22-1940 Registrar: J. J. Murphy

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 19 1940, at 4P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 17 1940 to July 19 1940, and that I last saw him alive on July 19 1940.

	DURATION
Immediate cause of death: Bilateral Lobar Pneumonia	3 days
Due to: Arteriosclerosis	uncertain
Due to: Chr. Nephritis	uncertain
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work? ____

23. SIGNATURE: George C Bond
M. D. or other

Address: Annapolis Md Date signed: 7-19-40

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (46B)

CERTIFICATE OF DEATH

07233

Reg. Dist. No. 21

1. PLACE OF DEATH:

County A.A.

City or town Annapolis (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 44 Southgate Ave

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days) 40 Years

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County A.A.

City or town Annapoils, Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No. 44 Southgate Ave (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Robert B. Wayson

3. (b) Social Security Number None

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Widowed

6 (b) Name of husband or wife Alice A Wayson

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 29 1862

8. AGE: Years 77 Months 11 Days 2 If less than one day hrs. min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Retired Farmer

11. Industry or business

FATHER 12. Name John Wayson

13. Birthplace Maryland

MOTHER 14. Maiden name Elizabeth Virginia Stallings

15. Birthplace Anne Arundel Co., Md.

16. Informant Mrs Albert L. Anderson

Address 44 Southgate Ave Annapolis,

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3 1940 (month) (day) (year)

Cemetery or crematory Mt Zion

Location Mt Zion Maryland

18. Funeral director B.L.Hopping

Address Annapoils, Md.

19. 7 3 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH July 1, 1940, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1940, to July 1, 1940, and that I last saw him alive on July 1, 1940.

Immediate cause of death Carcinoma of Stomach

Due to Unknown

Due to

Other conditions Gastric hemorrhage (Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

DURATION 3 yr. Immediate

PHYSICIAN Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Albert L. Anderson MD M. D. or other

Address Annapolis, Md. Date signed 7/7/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07234

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yrs. 6 mos. 20 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 2 yrs. 6 mos. 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City (If outside city or town limits, write RURAL and give nearest town)

Street No. 1218 Whatcoat Street (If rural, give LOCATION)

2.(a) If veteran, name war: ------

3. (a) FULL NAME: SAMUEL WHITE

3. (b) Social Security Number: -----

4. Sex: Male

5. Color or race: black

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of ~~husband~~ or wife: Julia White

6.(c) If alive, give age: ? years

7. Birth date of deceased (mo., day, yr.): 1912

8. AGE: Years: 28 Months: Unknown Days: If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: General

FATHER

12. Name: Ham White

13. Birthplace: Maryland

MOTHER

14. Maiden name: Mary Rogers, dead

15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 8/5/40 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md.

18. Funeral director: Supt

Address:

19. Aug 5 1940 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30th 1940 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 10th 1938 to July 30th 1940 and that I last saw him alive on July 30th 1940

Immediate cause of death: Syphilis

Due to:

Due to:

Other conditions: ------

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: -----

---- Date of op.

Autopsy results: -----

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of:

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ------ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Md. Date signed: 7/30/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07235

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 11 mos. 15 days
Hospital, institution, or street address where death occurred: CROWNSVILLE STATE HOSPITAL
How long in hospital or institution? 1 yr. 11 mos. 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Washington
City or town: Hagerstown
(If outside city or town limits, write RURAL and give nearest town)
Street No. 309 N. Jonathan St.,
(If rural, give LOCATION)
2.(a) If veteran, name war: none

3. (a) FULL NAME
NANNIE WILSON

3. (b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Isaac Wilson
6.(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): 1889

8. AGE: Years: 51 Months: Unknown Days: If less than one day ... hrs. ... min.

9. Birthplace: Virginia (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: General
FATHER 12. Name: William Taylor
13. Birthplace: West Virginia
MOTHER 14. Maiden name: Ella Granthum
15. Birthplace: West Virginia
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal, Which?) Date thereof 7-20-40 (month) (day) (year)
Cemetery or crematory: Hagerstown Md
Location: Rose Hill Cemetery
18. Funeral director: John M Caldwell
Address: Hagerstown Md
19. 7 18 1940 (Date rec'd by registrar) J J Murphy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17th 1940 at 4:30A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 2nd 1938, to July 17 1940 and that I last saw her alive on July 17th 1940

Immediate cause of death	DURATION
General paralysis of the insane	
Due to	
Due to Lues	
Other conditions ------	

(Include pregnancy within 3 months of death)
Major findings of operations: -----
Date of op.
Autopsy results: ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ------
Means of injury Injured at work? ------

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Md. Date signed 7/17/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

Bureau of Vital Statistics, Baltimore (63-6) Reg. Dist. No. 23

07236

CERTIFICATE OF DEATH

1. PLACE OF DEATH:
(a) County Anne Arundel
(b) City or town Linthicum (If outside city or town limits, write RURAL and give town)
(c) Street address, hospital, or institution: Hammonds Ferry Rd.
(d) Length of stay in hospital or inst. (yrs., mos., or days)
(e) Length of stay in this community (yrs., mos., or days) 17

2. HOME (USUAL RESIDENCE) OF DECEASED:
(a) State Md (b) County A. A.
(c) City or town Linthicum (If outside city or town limits, write RURAL and give town)
(d) Street No. Hammonds Ferry Rd. (If rural give location)
(e) If foreign born, how long in U. S. A.? years

3 (a) FULL NAME Robert Agustus Wilson

3 (b) If veteran, name war

3 (c) Social Security No. none

4. Sex Male

5. Color or race White

6 (a) Single, married, widowed, or divorced. Married

6 (b) Name of husband or wife Frankie Dismukes Wilson

6. (c) If alive, give age 49 years

7. Birth date of deceased (mo., day, yr.) March 29, 1879

8. AGE: Years 61 Months 3 Days 7 If less than one day hr. min.

9. Birthplace Altuna Pa. (Town, county, and state)

10. Usual occupation Electrical Engineer

11. Industry or business General Electric Co.

FATHER
12. Name Geo. Wm Wilson
13. Birthplace Louisville Ky.

MOTHER
14. Maiden Name Letitia Johnson
15. Birthplace Altoona Pa.

16 (a) Informant Wife
(b) Address Hammonds Ferry Rd.

17 (a) Burial (Burial, cremation, or removal) (b) Date thereof July 8-1940 (month) (day) (year)
(c) Cemetery or crematory Friendship
Location Camp Meade Rd. A A Co. Md

18 (a) Funeral director Wm J Leckner & Sons
(b) Address North 1 Pa Ave Balto. Md

19 (a) 7 July 1940 (Date rec'd by registrar) (b) [illegible] Registrar

MEDICAL CERTIFICATION

20. Date of death July 6 1940, at 3:30 A M

21. I certify that death occurred on the date above stated; that I attended deceased from Feb. 1937, to July 6 1940, and that I last saw him alive on July 6 1940.

Immediate cause of death	Duration
Cardio-Vascular disease	1931
Due to Toxic Thyroid	1930
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
(e) Means of injury

23. Signature Chas. L. Ball Jr. M.S. M. D. or other
Address Linthicum, Md. Date signed 7-6-40

VS. A15 (T) (I) (M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
AUG 5 1940
BUREAU V. S.

07237

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(138)

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days): —
Stay in this community (yrs., or mos., or days): 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Anne Arundel
City or town: Severn Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR: —

3. (a) FULL NAME: Grace Edna Zaukus

3. (b) Social Security Number:

4. Sex: F.
5. Color or race: W.
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: John Zaukus
6(c) If alive, give age: 40 years
7. Birth date of deceased (mo., day, yr.): Sept 5-1905

8. AGE: Years 34 Months 10 Days 12 If less than one day ___ hrs. ___ min.

9. Birthplace: Baltimore. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Home
FATHER
12. Name: Wm E. Zaukus
13. Birthplace: Baltimore
MOTHER
14. Maiden name: Maud Sanford
15. Birthplace: Baltimore
16. Informant: Albert C. Leimbach
Address: 605 Pontiac Ave Brooklyn Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: July 19 1940 (month) (day) (year)
Cemetery or crematory: Western
Location: Baltimore Md
18. Funeral director: Wm J. Tickner & Sons
Address: North & Penna Ave
19. July 18 1940 (Date rec'd by registrar) Mrs DeAlba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 17 1940, at 1A 55 M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1939, to July 17 1940, and that I last saw her alive on July 14 1940
Immediate cause of death: Pulmonary T.B.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings:
Of operations:
Of autopsy:

DURATION

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. or other
Address: Clinton Md Date signed: July 17-40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Matilda De Alba

Dr Caldwell Woodruff
Linthicum